Governor's Office of Health Policy & Finance
Rural Health Work Group

Meeting of October 27, 2006

Minutes

The first meeting of the Governor's Rural Health Work Group was held Friday, October 27, 2006, in Room 105 of the Cross Office Building, Augusta, Maine. Work group members present included: Wayne Myers, Chairman; Marjorie Love; Bob Down; Carol Carothers; Ralph Gabarro; Roger Renfrew; Bill Diggins; Mike Senecal; Barbara Peppey; and Phil Caper. The entire project "team" was also present: Trish Riley; Ellen Schneiter; Charles Dwyer; Andy Coburn; Jonathan Sprague; and Stephenie Loux.

Dr. Myers began the meeting by sketching out the objective of the Rural Health Work Group (RHWG). That is to scope out and define the urgent issues in rural health in Maine, identifying information to inform this task as well as gaps in needed information, all with the goal of helping to formulate the state's Rural Health Plan. Jonathan Sprague elaborated on these observations. He noted that the RHWG's work will span from October through the end of February, 2007. The actual work product will be a heavily annotated "table of contents" for a new Rural Health Plan. The group will identify issues, will prioritize those issues and will develop recommendations that will serve as the framework for the new Rural Health Plan. Andy Coburn added that it will not be possible to address the entire range of issues challenging rural health and that choices will have to be made. This process will be iterative and will not end with this group's immediate work; instead, once a new Plan is developed, it will be subject to on-going assessment and will change over time, as needs change. Andy also noted that the RHWG will provide recommendations to both the Governor and his Advisory Council on Health Systems Development (ACHSD). The ACHSD also advises the Governor, through its work with his Office of Health Systems Development.

Trish Riley then described how the work of the RHWG relates to the broader efforts of the Dirigo Health Reform initiative. She pointed out that one of the most significant challenges we face is that we have no long range vision for our rural health system, which leaves policymakers and others in a reactive stance whenever a crisis in rural health arises. One of the Administration's goals is to make Maine healthier, moving it toward a position of being the healthiest state in the country, as laid out in the State Health Plan. Trish pointed out the importance of taking an active stance on rural health and health care if we are to meet that goal. She noted that the State Health Plan and the Rural Health Plan are not about State government, but about the state as whole. Collaboration is key to this effort, which is why there has been concerted action to engage opinion leaders, experts and community representatives at all levels from all areas of the state. The composition of the RHWG demonstrates this, as is the composition of the Public Health Work Group (PHWG). The PHWG is focused on defining the elements of a strong system of public health for our state, which is important to rural health and

rural health care. The RHWG can build on the work of that other group and can also incorporate the work being done by the Telemedicine Work Group. Riley asked the group to be strategic and develop focused suggestions, stressing the need to be "reductive" by focusing on a small set of issues where we might make significant impact.

Jonathan Sprague then outlined the proposed process that the group will engage in. The State Health Plan serves as the core document guiding the work of the RHWG. There is no intention to reinvent the wheel; instead, this effort should build upon good work already done, teasing out what is most relevant to rural communities. He noted that the project team has copies of several Rural Health Plans from other states; these plans can provide ideas and may serve as a framework for Maine's own plan. He challenged members to think about reports and other documents they have come across that may be useful to the RHWG and bring them to the attention of the project team, so they may be shared with other members. Similarly, members may be asked to provide the project team with references to other experts and opinion leaders who can be helpful to this process. RHWG members who do not have access to a copy of the Institute of Medicine report on rural health were asked to contact Stephenie Loux of the project team; Stephenie will obtain a copy of the report for each member requesting one.

One member raised the question of whether the focus of this work was to be rural health or the rural health system. He pointed out that the two are not synonymous and, in fact, the health system likely has very little to do with health status, which probably is most heavily influenced by income. This is a very important distinction; Andy noted that the Institute of Medicine report on rural health recognizes this same issue. He suggested that the framework established by the IOM committee does a good job of linking the health system and health status.

Another RHWG member asked whether it was within the scope of this group to potentially recommend consideration of new models of health delivery in rural communities. This would be a credible suggestion.

Andy then presented an overview of the IOM rural health report, noting that the work of the IOM committee and the RHWG are entirely consistent. This generated a discussion of the use of the term "systems." Jonathan noted that we are not limited to focusing on the delivery system but, rather, we should be examining how we interconnect all of the pieces/factors that influence and impact health at the community level. A member noted that the IOM remains very clinically oriented, instead of focusing more broadly on other determinants of health, especially income. It was posited that historically, efforts to improve health – in both rural and urban communities – have "shadowboxed" with symptoms (such as the state of the health care system) as opposed to the underlying disease, which was characterized as the polarization of wealth between the rich and the poor. The argument is that if we continue to treat symptoms rather than the disease we will only perpetuate the problem and will forever be engaged the mode of crisis management that we wish to move away from.
The group then moved into a brainstorming session, sharing each person's view regarding the most pressing issues challenging health in Maine's rural communities.

These issues ranged from unrealistic public expectations of the health system to maldistribution of resources to an under use of extant resources. Below is a very brief description of the issues put on the table.

- The public expects instant EMS response time. At the same time, relatively low call volume necessitates fairly large service areas, increasing distances between the EMS center, residents and the hospital. Still, EMS personnel – who are well trained health providers – have considerable periods of downtime. It might be helpful to use them as care extenders in rural community, given their unused capacity.
- Access was cited as an important issue, with the emergency department acting as a major gateway into the health care system.
- Transportation (non-emergency transport) is an issue.
- Lack of support for local care givers might suggest the need for developing neighborhood networks.
- Categorical funding can inhibit creative uses of revenue that might result in better services and better outcomes.
- We should be certain to pay attention to other work done in Maine and nationally, that might be used as models for our work here.
- Maine's health workforce is in jeopardy ("you can't do it if you can't staff it"); historically, we have focused on improving recruitment, but that strategy is unsustainable if there is no pool to recruit from. Need to focus more downstream, encouraging children to think about careers in health care – and not just in health delivery, but in all aspects of the system (e.g. accounting for health providers).
- Optimal distribution of health care resources needs to be addressed
- We need to decide what our focus should be: rural health or rural health systems. Rural health systems are really a subset of rural health, but only a part and probably not a significant part, at that.
- While the IOM report is commendable, it does not represent any new ideas
- Perhaps the issue is not health care any longer; perhaps it is all about money now. This issue has been raised several times during the course of the meeting; the group discussed how answers to the issue might be operationalized, which will necessarily have to be incrementally as opposed to revolutionarily.
- Maine needs good paying jobs and a strong economy to improve health.
- System financing and incentives need attention.
- We need to be clear about what rural health *is* if we are going to be developing appropriate policy recommendations.
- What is the role of individual responsibility and accountability?
- Need to consider funding incentives to create change.
- Training is currently insufficient.
- Integration is lacking; everyone operates in their own silo.
- We need to build stronger infrastructure, especially in the area of mental health to keep people out of the hospital – need early intervention.

- Transportation and access are particular issues in rural communities, especially in terms of mental health.
- Our workforce is aging – how will we continue to maintain health system capacity as both the workforce and community grows older?
- Disease management for people living with chronic illness represents an important opportunity. At the same time, financing incentives often don't pay for what makes the most sense.
- It is important to recognize and celebrate the successes we've had. These include the Healthy Maine Partnerships, efforts to integrate mental health into primary care, our leadership in chronic disease management by groups like Quality Counts and efforts to develop leadership in health and health care like those undertaken by the Hanley Forum. Similarly, the work of our FQHCs and Critical Access Hospitals is very important to rural health and health care.
- Health care workforce supply, especially in the area of primary care, is an important issue.
- We need new models for providing primary care, new models for quality within communities are needed as well.
- Information technology is an important consideration, as is the appropriate distribution of resources and services and the lack of integration plaguing the system.
- Lack of adequate and affordable health insurance is problematic.
- It will be important to look at the viability of our Critical Access Hospitals over the long run, since conversion to CAH status does not guarantee sustainability.

The project team added some of their own observations. These included the importance of identifying performance expectations (indicators or measures) so we are able to mark progress toward our goals. These might include financial indicators, measures of community impact, and quality measures. It was also noted that federal partners often fail to live up to their responsibilities; we need to recognize their role and call them to task. The concern about access is shared with RHWG members, both in terms of access to primary care and to specialty care. Cultural competency is of special concern as is integration of services and oral health.

The brainstorming session identified several documents that will be obtained for members. These include a paper by Kevin McGinnis regarding rural EMS; Mike Senecal will provide the team with the citation for the paper. Similarly, Phil Caper commended two articles to the group one entitled "Damaged Care" and the other "Health and Wealth." Finally, Ralph Gabarro noted that some good work had been done by the Flex Grant Monitoring Team and the University of North Carolina around the issue of CAH financial sustainability.

Next steps were then discussed. Stephenie will survey members regarding their availability for a meeting the week following Thanksgiving and in early January. It is hoped that, by the date of the next meeting, work on identifying priority areas will be ready to present to RHWG members. Members will then be asked to self-identify the

priorities they have special interest in, as the short working time for this group may be best served by the formation of smaller "task forces."

Ellen noted that a page has been added to the Dirigo website for the RHWG. Meeting schedules, agendas, minutes, reading materials, and so on, may be posted on that page. The page may be accessed by going to www.dirigohealth.maine.gov and clicking on News and Information, then by clicking on Rural Health Work Group.

Jonathan noted that a lot of communication with members will occur via email.

At the close of the meeting, Dr. Myers offered those members of the public attending the meeting an opportunity to comment.

The meeting adjourned at approximately 4:00 pm.